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Commentary on Szasz

G Adshead

Szasz argues that the threat of harm to self or others cannot be understood as a symptom of mental illness, and that there is an irresolvable tension between the traditional medical ethical duty to heal, and any notion of a medical duty to protect the public.[1] I think these are two distinct arguments which could each be the subject of extended analysis, and this commentary is of necessity limited.

Professor Szasz has consistently raised concerns about the political abuse of psychiatry as a way of controlling dissidence. Many of his arguments remain as cogent and unanswered as when they were first put 30 years ago. But as sympathetic as I am to some of his criticisms, it seems to me that many are too sweeping; especially the first claim that there is no such thing as mental illness, but only persons whose expressed intentions involve taking a stance which is contrary to certain social rules.

I do not propose here to discuss the so called "hard" problem of consciousness—that is, exactly how brain states give rise to intentional psychological experience, or indeed, the extent to which "brain" and "mental" can be used synonymously. If we accept that mental states give rise to intentions, then different mental states will give rise to different intentions, and there is no reason not to think that there might be abnormal mental states that might give rise to abnormal intentions. The question then is what we mean by the word "abnormal". Clearly it is possible for abnormal to be defined as "socially inappropriate", which is Szasz's concern. In that case, political and social dissidence is then turned into a symptom by the language of medicine, and thus becomes not a social matter, but an individual's personal problem.

But "abnormal" could be defined with reference to the individual, and not the group—that is, this state of mind is abnormal for Jim, rather than the group to which Jim belongs. For example, if Jim is diabetic and becomes hypoglycaemic, he may become stressed and anxious. His perception of threat may be lowered, and his ability to monitor his external world is reduced. In a confused and agitated state of mind, he forms the intention to hit his wife. What are we to make of this intention?

If Jim is not regularly in the habit of hitting his wife, we might want to argue that this intention is highly abnormal for Jim, and we would be inclined to say that this intention is the product of an abnormal mental state. We might want to stop Jim from doing this, not because hitting wives is socially deviant, but because we have a sense that Jim does not really "own"'this intention; it is not really "him". If we are trying to be respectful of other persons (an essential medical ethical duty, and arguably a fundamental human ethical duty), then we certainly want to respect their intentions, but we want to be sure that they are sincerely held and integral to the actor's identity and values.

It is therefore essential to find out first, whether Jim is in the habit of hitting his wife, and second, whether Jim was hypoglycaemic. If he is not an established batterer, and did miss a meal after insulin, then it seems reasonable to argue that he was in an abnormal mental state for him, and that his intention to harm another was a symptom. If he is a regular batterer, then we may not be so sure that the intention to harm is a symptom. It is not possible to say that the intention to harm others is always a symptom of abnormal mental states; however, it is also not possible to say it is never so. Context and history are more important than behaviour for assessing intentions; because it is the meaning of the intention to the person who does it, that tells us about its abnormality. It is also the meaning of the intention that will be used later to attribute responsibility and blame.

Szasz restricts most of his article to a passionate defence of the right to commit suicide, arguing that respect for individual autonomy requires us to let people hurt themselves. Of course, the political tension here is between the interests of the individual and those of the group. It is naïve, however, to think that no other person is harmed when individuals kill themselves, as the recent case of Miss B indicates.[2] Other commentators noted the effect on the medical staff around her, and other disabled people.[3 4] I do not have the space (nor is it entirely relevant) to present all the arguments against a right to commit suicide; I can only at this point make the point that others may not be wronged by such an act, but they may be harmed. People who live together in social groups do reserve the right to make rules that limit individuals' capacities to harm each other, and it seems therefore reasonable to be cautious about an unlimited right to suicide. Furthermore, liberty to do something is not the same as the licence to do anything. The whole structure of law may be seen as based on the notion that there are "wise restraints that make men free".[5] Lastly, there is some factual evidence to suggest that the wish to commit suicide

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may be fleeting and unstable, and may sometimes be the product of an abnormal mental state. It is therefore necessary to be cautious about automatically accepting any expressed intention to commit suicide as an inalienable right to individual liberty that must be respected. This is especially so since the choice to waive one's right to life is irrevocable.[6]

The really difficult task then is the discernment of when an intention is competently made, and when it does not reflect the real wishes of the person concerned. To begin with, there is a problem with the word "real". Peoples' intentions may change for many reasons, and are influenced by context and interpersonal relationships. Both Primo Levi[7] and Tzvetan Teodorov[8] describe how, in terrible circumstances, people can come to make both morally affirming and morally appalling choices. Our intentions towards people we know differ from those towards people we don't know because our relationships are different.

There are also different levels of intentionality or choice making process. There is a primary level of intention, where choices are simple: shall I put on a coat or not? A secondary level of intention involves a more complex choice making procedure, involving a degree of reflection: what do I feel about this? A third level of intention involves more complex choices still, involving not only reflection on one's own mental states, but also on those of others: how should I treat others? What sort of person do I want to be?

It is at this third level of intention that we want to be able to assess the competence of the actor: to know that her wishes represent a complex level of decision making about herself and her values. Unfortunately, we know more about how mental disorders might affect the first and second levels of intention than the third. Any mental disorder that affects perception and interpretation of percepts is likely to interfere with first level intentions, and these in turn may affect the second level. I am unlikely to be able to tell the difference between a Rembrandt and a Bacon unless I can tell the difference between eggs and bacon.

But it is at the third level of intentions that actors enter the moral domain; the discourse of "ought and should" not "can and will". We do not know very much about how or whether abnormal mental states give rise to abnormal third level intentions. The decision to commit suicide has third level intentional components in it: I'm better off dead, no one will miss me, and it doesn't matter if I am dead. Deciding that this is an intention that is really coherent is not an easy process, and neither psychiatry nor neuropsychology has much to say about it. And if the decision to harm oneself is a complicated procedure, then how much more so is the decision to harm another person.

The intention to harm others is a complex third level intention, even in those cases where there appears to be little thought about it. Many factors go into making this decision, of which abnormal mental states may just be one. Just as it meaningless to say that all violence is a symptom of mental disorder, it is equally meaningless to say that it never is. Research on violence in the community shows that some types of abnormal mental state do give rise to violence, or increase the likelihood of it happening. Social and demographic factors are more important than individual ones; but individual ones do count for something.

The question then is so what? Szasz deals briskly with the question of the threat of violence as a symptom, saying there is not much to say. But it seems to me that there is a great deal to say. If violence represents a breaking of social boundaries controlling aggression, then the intention to commit violence will always involve not only the individual perpetrator and victim, but also the social group to which they belong. People who do violent things put themselves outside their social group, to the same extent as that same group then rejects them. This is why violence can be (and probably most often is) an expression of political dissidence, rather than individual pathology.

What should psychiatry's response be? Optimists will see the empirical glass as half full: there is little connection between mental disorder and violence, and so psychiatry can get on with looking after the needs of the ill, and caring for them. Pessimists can say that the glass is half empty, and that if there is a connection, then psychiatry has a duty to prevent the patient causing harm to others, in the same way that they have a duty to relieve other symptoms.

The difficulty here is that helping others to behave better is not normally understood as a medical duty; moral health is not the same as medical health. This is particularly true for psychiatry, where there has been a long struggle to make clear that not everyone who behaves oddly is morally deviant. One can't then, however, have it both ways: if someone behaves in ways which are defined as morally deviant, it is going to be hard to argue that it is not "really" so, but that they are in fact medically ill. The only way to know is to find out more about the person's intentions at the time, and that can be a long drawn out process.

The other difficulty that Professor Szasz might have mentioned (as he has done in the past) is how psychiatrists discriminate against the mentally ill when they get involved in violence prevention. Apart from the mentally ill, no other group of citizens is required to behave better as evidence of their mental health, and no other group of citizens are assumed to be ill because they behave badly.

The main justification for psychiatrists being involved in violence prevention relies on the association, although small and rare, between abnormal mental states and violence. Given that this association does exist, it might also be argued that society has a claim on expert professional knowledge that might assist in keeping the social group safe. On what grounds can it be argued that professional knowledge can be used only for the benefit of individuals, and not the groups to which they belong? On this argument, there would be no public or occupational health. Although a refusal by psychiatry to engage in public protection might seem like a liberal position in terms of respect for autonomy, it also reflects a deeply conservative position in terms of seeing the relationship between the state and the individual as adversarial. Doctors are always understood to support the individual patient against an intrusive and controlling state; but

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what if it is the patient who is doing the intrusion and coercion?

Where I agree with Professor Szasz is in the importance of language in the medicalisation process, and I wish he had said more about this. The morally distasteful aspect of the psychiatrist as agent of social control lies in the deceit, and the linguistic sleight of hand that takes place when relieving social fear is reframed as doing good to the needy. If it is true that expert psychiatric knowledge has information of value in terms of risk reduction and prevention, then society could retain independent psychiatric experts to use this knowledge on society's behalf. We could have special police psychiatrists and court risk assessors, whose relationship with the assessed would not be that of the traditional doctor and patient, but that of the forensicist and client.[9] It seems to me that *transparency, objectivity*, and *honesty* are the key words here.

Professor Szasz has left open some even bigger questions about the ethical identity of doctors, and social harms. Do we ever stop being doctors? If so, how do people get to be our patients, and who gets to decide? What is the nature of the relationship between the doctor and society? And does it make sense to treat violence as a public health problem?

In the film *Minority Report*, highly specialised individuals "see" into the future, and also "see" the murderous intentions of others before they become an action. Their knowledge is used by the state to prevent violence from happening. A colleague and I noted the links with current psychiatric and social preoccupations with risk[10]; we also noted the dangers. We also pose the question: to what extent must individuals pay the price for the security of the group? It seems certain that psychiatry and psychology may have information that could contribute to social security; what seems much less certain is whether and to what extent it may be ethically justifiable to use it.

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Dangerousness, mental disorder, and responsibility

J R McMillan

While the UK Home Office's proposals to preventively detain people with what it has called dangerous severe personality disorder (hereafter DSPD) have been subjected to debate and criticism the deeply troubling jurisprudential issues in these proposals have not yet entered into public debate in a way that their seriousness deserves.[1] It is good that a commentator as well known as Professor Szasz is speaking out on this issue.

Professor Szasz focuses upon a crucial question by calling into question the medicalisation of terms like dangerousness and mental illness.[2] There is a great temptation for legislators and the public to treat these terms as if they are purely scientific terms and to think of risk assessment as a precise science. I don't share Professor's Szasz's worry about how psychiatry is using these terms but I think there are some important questions about how these concepts function in the public sphere.

This issue is important enough to justify the use of some rhetorical claims because such claims can serve to bring out what are neglected and important issues. In raising the following objections I am not attempting to refute the message that is in Szasz's article or to say that he is not making an important point but rather to attempt to sharpen the issues and to suggest ways that we can respond to Professor Szasz's challenge.

Psychiatry has progressed in a number of ways since Professor Szasz wrote *The Myth of Mental Illness*.[3] The science is much better, we have much better medications, and psychiatrists (at least all the psychiatrists that I know) are acutely aware of the tension between treating their patient and their obligations to the public interest.

So when Professor Szasz says: "Psychiatrists offer to relieve the disturbed person of the burden of coping with his disturbed relative by incarcerating the latter and calling it 'care' and 'treatment'", this is a fairly prejudiced and outdated view of

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